



Original article

Mental Health and Wellbeing Outcomes Among Trans Young People in Australia Who Are Supported to Affirm Their Gender



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A B S T R A C T

Purpose: Young trans people face elevated rates of poor mental health and well-being outcomes. Affirming their gender in ways that are meaningful to them has important implications for these outcomes. However, limited research has examined the role of feeling supported to affirm their gender.

Methods: This study used the data of 1,697 trans youth drawn from a large survey of LGBTQA+ 14–21-year-olds in Australia. Regression analyses examined how feeling supported to affirm gender medically, legally, or socially, among those who expressed a desire to do so, was associated with mental health and well-being outcomes.

Results: Participants who felt supported to affirm their gender medically, legally, or socially, reported less suicidal ideation and self-harm in the past 12 months as well as lower psychological distress, lower anxiety, and greater happiness. Support for medical and legal affirmation was associated with less suicide attempt in the past 12 months. Support for each form of gender affirmation was associated with lower odds of experiencing bias-based verbal and sexual harassment in the past 12 months, with support for legal and social affirmation associated with lower odds of experiencing bias-based physical harassment. Support for each form of gender affirmation was associated with lower odds of experiencing homelessness.

Discussion: Supporting trans youth to affirm their gender in the ways that are meaningful to them is key to their health and well-being. Those who are in a position to provide support to young trans people to affirm their gender must be encouraged and equipped to do so.

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IMPLICATIONS AND
CONTRIBUTION

Supporting trans and gender diverse youth to affirm their gender in ways that they wished to (medical, legal or social) was associated with better mental health and well-being outcomes, including less suicidality and psychological distress, greater happiness, and less experiences of harassment. Supporting trans youth through their individual gender-affirmation journeys is crucial to their well-being.

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Transgender people of binary and non-binary gender identity (hereafter referred to as 'trans') frequently face discrimination, harassment, and abuse during their formative years, leading to high rates of psychological distress and suicidality [1–5]. The

largest nation-wide survey to date of LGBTQA+ young people in Australia, from which the data for the present study is drawn, revealed that trans young people experience markedly higher rates of mental health difficulties compared to cisgender sexual minority people [6]. For example, nearly 77% of young trans women, 73% of young trans men, and 70% of non-binary young people reported experiencing suicidal ideation in the past 12 months [6]. These rates are considerably higher than the already high rates of cisgender sexual minority women and men from the same survey (56% and 46%, respectively).

Affirming gender is important for young people's mental well-being. Young people may affirm their gender through social transition, such as changing their name, pronouns, or expression of their gender through clothing and behavior; medical gender affirmation, such as hormone therapies or surgical treatments; or legal recognition of their gender by changing legal documents to reflect their identity. However, desire for these forms of gender affirmation varies, and not all young people will follow the same gender affirmation journey [7,8]. Using the same dataset as this present study, Grant et al. [7] demonstrate that young trans people who *actively* affirmed their gender, whether legally, medically, or socially, reported overall better mental health and well-being. Similar research from Brazil found that accessing multiple forms of gender affirmation was associated with less anxiety and fewer depression symptoms [9]. While this evidence shows that affirming gender identity is essential for mental health and well-being, there is limited research on the impact of *feeling supported* in accessing gender affirmation among young people. While the Grant et al. [7] study explored mental health and well-being outcomes associated with *actively* affirming gender among young people, the present study will examine mental health and well-being outcomes associated with *feeling supported* to affirm gender in the ways that they wish to.

Unfortunately, trans young people can face considerable barriers to affirming their gender, whether legally, medically, or socially. Barriers can stem from health care systems, legal systems as well as family dynamics, and lack of parent or carer support. Health care barriers include a shortage of trained providers, discriminatory practices, practitioner prejudice, high costs, and inadequate insurance coverage [10–13]. Further, trans people frequently encounter health providers who are not well-versed in caring for trans people, leading to delays or denials of necessary care [11,14,15]. Legislative measures in some regions restrict access to gender-affirming medical interventions and add additional bureaucratic challenges, costs, and time to changing legal documents. In Australia, prior to 2017, medical interventions for gender dysphoria, including puberty blockers or hormone treatments, required court authorization for young people [16]. Notably, the data used in the present study was collected in late 2019; therefore, participants may have desired or attempted to access medical gender affirmation prior to the law changing. Family and parent or carer rejection or lack of support adds another layer of difficulty [6,17], strongly correlating with adverse mental health outcomes for trans people, such as increased risk of suicidality, depression, or anxiety [18–21]. Moreover, qualitative research has demonstrated that youth with the lowest levels of parental support experience more system barriers to accessing hormone therapy [22], and even accepting parents may struggle to support their child's gender affirmation choices, leading to resistance or delays in their transition or access to gender-affirming care [17]. On the other hand, research has found perceptions of support from

parents for a young person's trans identity are associated with more positive well-being outcomes [23–25].

Elevated rates of poor mental health, suicidality and self-harm, homelessness, and experiences of harassment among trans youth are well-documented [3,6,26]. However, these negative outcomes are not inherent to being trans but result from broader societal responses, including stigma, discrimination, and lack of inclusion or affirmation of trans identities. It is therefore crucial to identify factors that can prevent or mitigate these negative well-being outcomes as well as contribute to positive well-being, such as subjective happiness. While the importance of access to gender affirmation [7,9] and support for gender identity [10,27–30] is increasingly demonstrated in the literature, less research has focussed on the significance of feeling supported in accessing gender affirmation. Using data from trans young people in Australia who expressed a desire to affirm their gender medically, legally, or socially, this paper aims to examine mental health and well-being outcomes, including suicide and mental health outcomes, subjective happiness, homelessness, and experiences of bias-based harassment (harassment based on LGBTQA+ identity) [31], associated with feeling supported to affirm their gender in these ways. It is expected that young trans people who felt supported to affirm their gender will demonstrate better mental health and well-being outcomes.

Method

Sample and procedure

The study utilized a national survey of 6,418 LGBTQA+ youth aged 14–21 in Australia. The present analyses focused on 1,697 trans participants who responded to the survey segment dedicated to trans experiences. The survey was designed in collaboration with a Community Advisory Board and Youth Advisory Group, which included people with expertise and lived experiences across a spectrum of gender and sexuality. Conducted online, the survey was open for responses in late 2019 and promoted via targeted social media advertising and promotion by LGBTQA+ community organizations. All questions were optional beyond those pertaining to eligibility criteria. Ethics approval was granted by the La Trobe University Human Research Ethics Committee.

Measures

Demographic factors. Demographic details collected included age, gender, sexual orientation, current educational level, and residence location. Participants selected their sexual orientation from 12 options, including 'gay,' 'lesbian,' 'bisexual,' 'pansexual,' 'queer,' 'asexual,' 'homosexual,' 'heterosexual,' 'prefer not to answer,' 'prefer not to have a label,' 'don't know,' and 'something different.' Due to smaller sample sizes and in an effort to honor participant's selected identify, 'homosexual' and 'prefer not to have a label' were grouped into a single category called 'something different.'

For gender identity, participants chose from 17 gender descriptors. Trans identity was determined based on the sex on their original birth certificate and their selected gender term. Final categories of gender used in this study included trans woman (reported male on their original birth certificate and identified only 'female,' 'trans woman,' or 'sistergirl' as their

gender identity), trans man (reported female on their original birth certificate and identified only ‘male,’ ‘trans man,’ or ‘brotherboy’ as their gender identity), and nonbinary (selected a gender term that was not a binary identity or indicated that they could not choose a single-gender identity).

Gender affirmation. Trans participants were asked about their desires to affirm their gender socially (i.e., change your name/pronouns or gender presentation), legally (i.e., change your legal name or gender markers on ID documents), medically (i.e., puberty blockers, hormone therapy, gender-affirming surgeries), or none of these. Multiple selections were allowed. Those desiring any form of affirmation were further questioned if they had actively affirmed their gender in these ways.

Supported to affirm gender. Participants who expressed a desire to affirm their gender socially, legally, or medically were asked if they had ever felt that their access to each form of affirmation had been ‘denied,’ ‘delayed,’ ‘controlled,’ or ‘supported’ to affirm in these ways. Participants were able to select as many of these options as applied to them. Responses were recoded into 3 binary variables indicating those who had experienced any of denied, delayed, or controlled versus those who only reported feeling supported for each form of gender affirmation (social, legal, and medical).

Suicidal ideation and attempt. To assess suicidal ideation and attempts, participants indicated if they had thoughts of suicide or desire to end their lives and whether they attempted suicide or made efforts to end their lives, with options ‘no,’ ‘yes, in the past 12 months,’ ‘yes, more than 12 months ago,’ and ‘prefer not to answer.’ Multiple responses were allowed unless ‘no’ or ‘prefer not to answer’ was selected. Binary variables were generated indicating recent suicidal ideation or attempts within the past 12 months.

Self-harm. Participants reported on self-harm with response options ‘no, never,’ ‘yes, in the past 12 months,’ ‘yes, more than 12 months ago,’ and ‘prefer not to answer.’ Multiple responses were allowed unless ‘no’ or ‘prefer not to answer’ was selected. A binary variable indicated recent self-harm within the past 12 months.

Psychological distress. The 10-item Kessler Psychological Distress scale (K10) [32] was used to measure level of psychological distress. The K10 assesses anxiety and depression symptoms over the past 4 weeks using a 5-point Likert scale from ‘none of the time’ to ‘all of the time.’ Scores range from 10 to 50, with higher scores indicating greater distress.

Anxiety. Generalized anxiety was measured using the generalized anxiety disorder assessment (GAD-7) [33], a 7-item scale asking about anxiety symptom frequency. Scores range from 0 to 21, with higher scores indicating greater anxiety symptoms.

Subjective happiness. Subjective happiness was measured using the 4-item self-report, globally validated Subjective Happiness Scale (SHS) [34]. A 7-point Likert scale is used to respond to items such as “in general I consider myself...,” with potential responses ranging from 1 “not a very happy person” to 7 “a very happy person.” After averaging responses, scores can range from 1 to 7, with a higher score suggesting increased happiness [35].

Homelessness. Homelessness was assessed by asking participants if they had ever fled home, been asked or forced to leave, couch surfed, or experienced homelessness, as defined by “the absence of a secure or safe place to live, which may encompass situations like sleeping outdoors, residing or sleeping in a car, shelter, hostel, or refuge.” Those who responded affirmatively were further asked if they were currently facing this situation, if it was within the past 12 months, or if it was more than 12 months ago. Responses were categorized into having ever experienced homelessness or not.

Experiences of bias-based verbal, physical, or sexual harassment in the past 12 months. Participants indicated whether they had experienced verbal, physical, or sexual harassment in the past 12 months based on their sexuality or gender identity by selecting all that applied to them from these 3 forms of harassment. Responses were coded as individual dichotomous variables for each form of harassment.

Statistical analyses

Statistical evaluations were performed using Stata (Version 16.1 SE; StataCorp, College Station, TX). Descriptive statistics were conducted to provide an overview of the sample’s socio-demographic attributes. Chi-square analyses were performed to determine if there were differences in the frequency of desire for access to and felt support to affirm gender medically, legally, or socially across genders (women, men, and nonbinary). Post hoc pairwise comparisons were then conducted to identify specific differences between each pair of gender groups. To correct for multiple comparisons, a Bonferroni adjustment was applied, setting the significance at $p < .0167$.

Subsequently, a series of multivariable linear and logistic regression analyses were performed to explore the mental health and well-being outcomes of participants who felt supported to affirm their gender medically, legally, or socially, among those who expressed a desire to affirm their gender in these ways. These analyses were used in order to examine the associations between predictor variables (felt supported to access medical, legal, or social gender affirmation) and outcome variables, while adjusting for potential confounding factors. Regression analyses were conducted separately for each form of gender affirmation (medical, legal, or social). Linear regression analyses were used when outcome variables were continuous, including K-10, GAD-7, and SHS scores. Logistic regression analyses were used when the outcome variables were dichotomous, including past 12-month suicidal ideation, past 12-month suicide attempt, past 12-month self-harm, ever experiencing homelessness, and past 12-month experiences of verbal, physical, or sexual harassment. Each of the regression models accounted for the potential confounding effects of demographic traits, including age, gender, sexual orientation, level of education, and residential location.

Results

Table 1 presents the demographic characteristics of the participants, illustrating diversity within the sample, including across age, gender, sexual orientation, level of education, and residential location. Almost 3-quarters of participants were nonbinary ($n = 1,216$; 71.7%), 23.9% ($n = 406$) were trans men, and 4.4% ($n = 75$) trans women. Age was fairly evenly split between those aged 14–17 (55.7%) and those aged 18–21 (44.3%). The

Table 1

Sample characteristics (n = 1,697)

	n	%
Age group		
14–17	945	55.7
18–21	752	44.3
Sexual orientation		
Lesbian	148	8.7
Gay	151	8.9
Bisexual	365	21.5
Pansexual	332	19.6
Queer	261	15.4
Asexual	113	6.7
Something else	326	19.2
Gender		
Trans woman	75	4.4
Trans man	406	23.9
Non-binary	1,216	71.7
Education level		
Secondary school (high school)	929	58.9
University	375	23.8
TAFE (Technical and Further Education; vocational education)	151	9.6
Other	121	7.7
Country of birth		
Australia	1,535	90.6
Other English-speaking country	97	5.7
Non-English-speaking country	62	3.7
Residential location		
Capital city, inner suburban	99	5.8
Capital city, outer suburban	916	54.1
Regional city or town	474	28
Rural or remote	205	12.1

sample was diverse across sexual orientation, with 21.5% identifying as bisexual, 19.6% as pansexual, 15.4% as queer, 8.9% as gay, and 8.7% as lesbian. Most participants were born in Australia (90.6%) and resided in outer-suburban areas (59.9%) or regional areas (28.0%). Over half were attending secondary school at the time of the survey (58.9%).

Table 2

Frequencies of hoping to and actively affirming gender medically, legally, or socially as well as feeling supported to affirm

	Trans woman		Trans man		Non-binary		Total		X ²
	n	%	n	%	n	%	n	%	
Medical affirmation									
Hoped to affirm	71	98.6	393	98.0	558	59.5** ^a	1,022	72.4	234.7**
Actively affirmed	34	47.9	177	44.1	90	9.7** ^b	301	21.5	227.0**
Felt supported to affirm	11	20.4	62	19.4	35	12.4	108	16.4	6.0
Legal affirmation									
Hoped to affirm	68	94.4	394	98.3	602	64.2** ^c	1,064	75.4	190.7**
Actively affirmed	19	26.8	132	32.9	89	9.6** ^d	240	17.2	111.7**
Felt supported to affirm	9	25.0	57	19.9	33	11.7** ^e	99	16.4	9.0**
Social affirmation									
Hoped to affirm	71	98.6	401	100.0	904	96.4** ^f	1,376	97.5	15.6**
Actively affirmed	53	74.6	369	92.0** ^g	609	65.8** ^h	1,031	73.7	99.6**
Felt supported to affirm	25	37.9	109	29.1	148	20.0** ⁱ	282	23.9	18.9**

***p* < .0167.^a Differs to trans women ($X^2 = 43.6$) and trans men ($X^2 = 202.5$).^b Differs to trans women ($X^2 = 88.2$) and trans men ($X^2 = 206.3$).^c Differs to trans women ($X^2 = 27.4$) and trans men ($X^2 = 171.2$).^d Differs to trans women ($X^2 = 20.08$) and trans men ($X^2 = 109.5$).^e Differs to trans men ($X^2 = 7.1$).^f Differs to trans men ($X^2 = 14.9$).^g Differs to trans women ($X^2 = 19.2$).^h Differs to trans men ($X^2 = 99.5$).ⁱ Differs to trans women ($X^2 = 11.5$) and trans men ($X^2 = 11.6$).

Table 2 provides frequencies of hoping to affirm, actively affirming, and feeling supported to affirm medically, legally, or socially across gender identities (men, women, and non-binary). In addition, this table provides χ^2 results comparing these frequencies between genders. **Figure 1** further visually represents the rates of feeling supported to affirm and highlights the significant differences across genders. Almost 3-quarters (72.4%) of participants hoped to affirm their gender medically, with trans women (98.6%) and trans men (98.0%) expressing higher rates of this desire than non-binary participants (59.5%). However, only 21.5% had actively pursued medical affirmation, with the rates being highest among trans men (44.1%) and lowest among non-binary participants (9.7%). Similarly, 75.4% of participants hoped for legal affirmation, but just 17.2% had done so, with trans men (32.9%) more likely to have affirmed legally compared to non-binary participants (9.6%). For social affirmation, 97.5% of participants hoped to affirm socially, and 73.7% had done so, though non-binary participants reported lower rates of actively socially affirming their gender (65.8%) compared to trans men (92.0%). Across all forms of affirmation, only 16.4% reported feeling supported to affirm medically or legally, and 23.9% reported support to affirm socially. Non-binary people were least likely to have felt supported to affirm their gender legally (11.7%) and socially (20.0%).

Table 3 presents the multivariable logistic regression and linear regression results exploring associations between feeling supported to affirm gender medically, legally, or socially and mental health and well-being outcomes.

Suicidality, self-harm and mental health

Compared to those for whom access to gender affirmation was denied, delayed, or controlled, those who felt supported to affirm their gender medically, legally, or socially had lower odds of experiencing suicidal ideation (medical: adjusted odds ratio (aOR) = 0.49, 95% CI = 0.30, 0.82; legal: aOR = 0.36, 95% CI = 0.21,

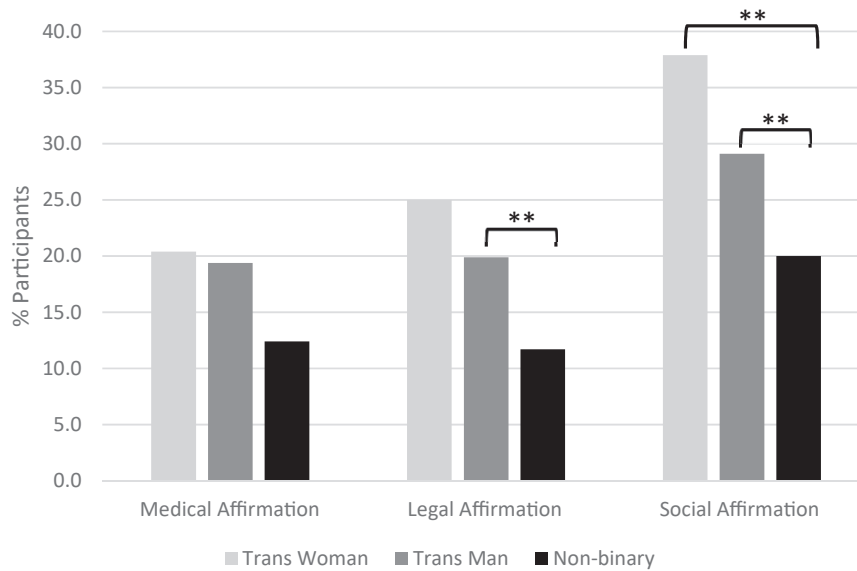


Figure 1. Rates of feeling supported to affirm medically, legally, or socially across genders, as reported in Table 2; $**p < .0167$.

0.61; social: aOR = 0.56, 95% CI = 0.40, 0.77). Similarly, support to affirm gender medically or legally was associated with lower odds of a recent suicide attempt (medical: aOR = 0.31, 95% CI = 0.14, 0.71; legal: aOR = 0.27, 95% CI = 0.11, 0.68). Feeling supported to affirm socially was not associated with suicide attempt in this sample. Support for medical, legal, or social gender affirmation was also associated with lower odds of recent self-harm (medical: aOR = 0.52, 95% CI = 0.32, 0.85; legal: aOR = 0.41, 95% CI = 0.24, 0.68; social: aOR = 0.64, 95% CI = 0.48, 0.86).

Moreover, those who felt supported to affirm their gender medically, legally, or socially reported lower total K-10 (psychological distress) scores (medical: $\beta = -3.07$, 95% CI = $-4.96, -1.19$; legal: $\beta = -4.61$, 95% CI = $-6.69, -2.52$; social: $\beta = -3.24$, 95% CI = $-4.40, -2.08$) and GAD-7 (anxiety) scores (medical: $\beta = -1.62$, 95% CI = $-2.98, -0.27$; legal: $\beta = -3.24$, 95% CI = $-4.65, -1.83$; social: $\beta = -1.67$, 95% CI = $-2.48, -0.87$) compared to those who felt their gender affirmation was denied, delayed, or controlled.

Subjective happiness

Higher SHS scores were observed for those who felt supported to affirm legally or socially compared to those who did not (legal: $\beta = 0.49$, 95% CI = 0.14, 0.84; social: $\beta = 0.33$, 95% CI = 0.14, 0.52). Although SHS scores were not significantly associated with support to affirm medically, it is notable that the β -coefficient trends in the same direction (higher SHS among those who felt supported to affirm medically).

Homelessness

Those who felt supported to affirm their gender medically, legally, or socially had lower odds of ever experiencing homelessness compared to those who felt their gender affirmation was denied, delayed or controlled by others (medical: aOR = 0.58, 95% CI = 0.35, 0.95; legal: aOR = 0.34, 95% CI = 0.19, 0.62; social: aOR = 0.49, 95% CI = 0.35, 0.68).

Bias-based verbal, physical, or sexual harassment

Finally, feeling supported to affirm their gender medically, legally, or socially was associated with lower odds of experiencing verbal harassment (medical: aOR = 0.34, 95% CI = 0.21, 0.55; legal: aOR = 0.26, 95% CI = 0.16, 0.44; social: aOR = 0.43, 95% CI = 0.32, 0.58) as well as sexual harassment based on their sexuality or gender identity in the past 12 months (medical: aOR = 0.33, 95% CI = 0.17, 0.64; legal: aOR = 0.23, 95% CI = 0.11, 0.51; social: aOR = 0.57, 95% CI = 0.39, 0.84). Feeling supported to affirm medically, but not legally or socially, was associated with lower odds of experiencing physical harassment based on their sexuality or gender identity in the past 12 months (medical: aOR = 0.28, 95% CI = 0.11, 0.72; legal: aOR = 0.41, 95% CI = 0.16, 1.01; social: aOR = 0.72, 95% CI = 0.45, 1.15).

Discussion

The findings of this paper expand on the existing and growing body of literature demonstrating the importance of access to gender affirmation for trans young people who seek to affirm their gender either medically, legally, or socially (e.g., 7, 9). Our findings indicate that support from others for accessing gender affirmation, whether medical, legal, or social, is associated with lower levels of psychological distress and anxiety, higher levels of subjective happiness, and lower odds of suicidality, self-harm, homelessness, and bias-based verbal harassment. Using the same dataset as the present study, Grant et al. [7] demonstrated that young people who had *actively* affirmed their gender medically, legally, and socially, had (overall) better mental health and well-being outcomes. The current findings extend those of Grant et al. [7] by highlighting the importance of *support* in gender affirmation.

The findings of the present study suggest that young people may have different desires for, access to, and different experiences of support in their gender affirmation hopes. It is particularly notable that non-binary people who wish to affirm their gender are considerably less likely to have actively affirmed their gender or to have felt supported to do so. These findings align

Table 3

Associations between feeling support to affirm gender medically, legally or socially and health and wellbeing outcomes

	Recent suicidal ideation				Recent suicide attempt				Recent self-harm			
	n	%	aOR(95% CI)	p	n	%	aOR(95% CI)	p	n	%	aOR(95% CI)	p
Supported to affirm medically												
No	413	77.2	REF	-	106	21.3	-	-	321	60.8	-	-
Yes	66	63.5	0.49 (0.30–0.82)	.007	11	10.7	0.31 (0.14–0.71)	.005	45	44.1	0.52 (0.32–0.85)	.009
Supported to affirm legally												
No	385	78.1	REF	-	92	19.9	-	-	300	62.1	-	-
Yes	58	60.4	0.36 (0.21–0.61)	.000	9	9.7	0.27 (0.11–0.68)	.005	40	43.0	0.41 (0.24–0.68)	.001
Supported to affirm socially												
No	681	77.8	REF	-	140	16.9	-	-	514	60.0	-	-
Yes	180	66.7	0.56 (0.40–0.77)	.000	35	13.4	0.65 (0.42–1.02)	.060	131	49.1	0.64 (0.48–0.86)	.003
	Psychological distress				Anxiety				Happiness			
	n	%	β (95% CI)	p	n	%	β (95% CI)	p	n	%	β (95% CI)	p
Supported to affirm medically												
No	-	-	REF	-	-	-	-	-	-	-	-	-
Yes	-	-	-3.07 (-4.96 to -1.19)	.001	-	-	-1.62 (-2.98 to -0.27)	.019	-	-	0.3 (-0.03 to 0.63)	.073
Supported to affirm legally												
No	-	-	REF	-	-	-	-	-	-	-	-	-
Yes	-	-	-4.61 (-6.69 to -2.52)	.000	-	-	-3.24 (-4.65 to -1.83)	.000	-	-	0.49 (0.14–0.84)	.006
Supported to affirm socially												
No	-	-	REF	-	-	-	-	-	-	-	-	-
Yes	-	-	-3.24 (-4.4 to -2.08)	.000	-	-	-1.67 (-2.48 to -0.87)	.000	-	-	0.33 (0.14–0.52)	.001
	Verbal harassment				Physical harassment				Sexual harassment			
	n	%	aOR(95% CI)	p	n	%	aOR(95% CI)	p	n	%	aOR(95% CI)	p
Supported to affirm medically												
No	373	69.3	REF	-	88	18.4	-	-	158	31.9	-	-
Yes	49	47.1	0.34 (0.21–0.55)	.000	7	7.1	0.28 (0.11–0.72)	.008	14	14.1	0.33 (0.17–0.64)	.001
Supported to affirm legally												
No	343	69.6	REF	-	79	17.9	-	-	159	34.8	-	-
Yes	39	39.8	0.26 (0.16–0.44)	.000	7	8.0	0.41 (0.16–1.01)	.053	11	12.6	0.23 (0.11–0.51)	.000
Supported to affirm socially												
No	565	64.1	REF	-	116	14.7	-	-	242	29.5	-	-
Yes	128	47.2	0.43 (0.32–0.58)	.000	32	12.8	0.72 (0.45–1.15)	.170	52	20.5	0.57 (0.39–0.84)	.004
Homelessness												
	n	%	aOR(95% CI)	p								
Supported to affirm medically												
No	233	42.8	REF	-								
Yes	31	29.2	0.58 (0.35–0.95)	.029								
Supported to affirm legally												
No	211	42.5	REF	-								
Yes	22	22.7	0.34 (0.19–0.62)	.000								
Supported to affirm socially												
No	349	39.2	REF	-								
Yes	76	27.0	0.49 (0.35–0.68)	.000								

with those of previous research [8,36] and may reflect additional barriers to gender affirmation faced by non-binary people, such as requirements in some Australian states that legal affirmation be contingent on medical affirmation, which not all non-binary people, or indeed trans women or trans men, may wish to pursue. Prior studies also highlight a level of medical gatekeeping by certain health care providers who may hold preconceived ideas about what the gender affirmation process should look like [37–39]. These ideas, rooted in cisgenderism, often emphasize 'transnormative' or binary gender transitions over more individualized approaches to gender affirmation [40].

With regard to mental health and suicidality, we found that experiences of support for all three forms of gender affirmation (medical, legal, and social) were associated with better mental health outcomes, including greater subjective happiness, and a lower likelihood of suicidality and self-harm in the past

12 months compared to those who felt that their access had been denied, delayed, or controlled in some way. Notably, these findings demonstrate more consistent associations for support to affirm gender with mental health and suicidality outcomes than what was found by Grant et al. [7] regarding *actively* affirming gender. While it is clearly important for the mental health and well-being of trans young people to access gender affirmation, these findings suggest that the experience of support, or lack thereof, from others to do so may at times overshadow the positive benefits of actively affirming their gender.

It is of interest that participants in our study who felt supported to affirm that their gender socially reported less suicidal ideation and self-harm and better mental health outcomes, while our earlier analysis by Grant et al. [7] did not find improved suicidality or mental health outcomes among those who had *actively* affirmed their gender socially. Actively affirming one's

gender socially may be associated with worse outcomes due to the disclosure of trans identity or living more visibly as a trans person, leading to increased experiences of discrimination and harassment and pervasive misgendering [41,42]. Our findings suggest that feeling supported to socially affirm may be protective against the risks of disclosing or being visibly trans. Accordingly, a study of trans young people in the United States, found that young people were more likely to run away from home and to attempt suicide when they had socially transitioned; however, they did not report these negative outcomes when they had supportive families [43]. In line with this US study, we additionally found that feeling supported to affirm gender medically, legally, or socially, was associated with a lower likelihood of having ever experienced homelessness. Increased familial acceptance and support for gender identity may reduce the likelihood of young people being expelled from home or feeling a need to leave an unsafe or harmful home environment.

Most notably, feeling supported to affirm gender socially, medically, or legally was associated with a lower likelihood of experiencing bias-based verbal harassment and sexual harassment in the past 12 months, while support to affirm medically was associated with a lower likelihood of experiencing bias-based physical harassment. The rates of harassment are generally high among trans young people [6], with these experiences found to increase with the visibility of a young person's identity [41,42]. In fact, Grant et al. [7] found that actively affirming gender socially was associated with an *increased* likelihood of experiencing bias-based verbal harassment. The findings from the present study stand out in comparison to those of Grant et al. [7]. We speculate two possible explanations. On one hand, the findings may imply that individuals who provide support to young people in affirming their gender also protect them from harassment. On the other hand, the findings might suggest that individuals who are relied upon for support could, in instances where they are not supportive, be the perpetrators of harassment.

Several limitations must be taken into consideration with regard to the current results. The study is based on broad questions about support, with limited detail of the source of the support or what the support looked like. Further in-depth explorations of what it means to support the gender affirmation journey of young people would make a valuable contribution to this field of research. Additionally, the use of convenience sampling means caution is required when generalizing the findings to the broader population of trans young people in Australia. The recruitment process may have excluded young trans people who have not disclosed their gender identity to others, do not feel safe participating in LGBTQA+ research, or are not engaged with the LGBTQA+ community or content. Our sample also included a high proportion of non-binary people and an underrepresentation of trans women, further necessitating some caution in interpretation when generalizing findings to the broader trans population. However, given the size of the sample and the alignment of the findings with existing research, we are confident these outcomes are likely to reflect the experiences of many trans young people. Finally, as the study was cross-sectional, it cannot determine the directionality of the associations between outcomes and support for gender affirmation.

The findings of this paper demonstrate the important role that support from others for gender affirmation journeys can play in the well-being of young trans people. Importantly, feeling supported to affirm their gender in ways that were meaningful to them was not only associated with less suicidality and mental

health concern but also greater happiness and a lower likelihood of experiencing homelessness and bias-based verbal harassment. It is interesting to note that we found more positive outcomes associated with *feeling supported* to access gender affirmation when compared to findings from the same dataset, which explored *actively* affirming gender [7]. While it is essential that trans young people are enabled access to affirm their gender in the ways that they wish to, if they do not have the support from others to do so and instead feel that their access to gender affirmation has been denied, delayed, or controlled by others, they may not experience the same mental health and well-being benefits. Supporting trans youth to affirm their gender in ways that are important to them is key to their health and well-being. More research is warranted to further explore the nuance of support experienced by trans young people and associated outcomes, including the type of support received (e.g., functional or emotional), who it comes from (e.g., families, peers, or health providers), and individual factors associated with experiencing support (e.g., age, cultural background or socioeconomic circumstance). The present study suggests that families, health providers, and others in a position to provide support to trans youth through their gender affirmation journey must be encouraged and equipped with the knowledge and skills necessary to do so. This may be achieved through policies, health practices, and public health resources that educate and provide guidance to these key supports.

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